WAC 296-20-01010 Scope of Health care provider network. (1) The rules establish the development, enrollment, and oversight of a network of health care providers approved to treat injured workers. The health care provider network rules apply to care for workers covered by Washington state fund and self-insured employers.

(2) As of January 1, 2013, the following types of health care providers (hereafter providers) must be enrolled in the network with an approved provider agreement to provide and be reimbursed for care to injured workers in Washington state beyond the initial office or emergency room visit:

(a) Medical physicians and surgeons;

(b) Osteopathic physicians and surgeons;

(c) Chiropractic physicians;

(d) Naturopathic physicians;

(e) Podiatric physicians and surgeons;

(f) Dentists;

(g) Optometrists;

(h) Advanced registered nurse practitioners; and

(i) Physician assistants.

(3) The requirement in subsection (2) of this section does not apply to providers who practice exclusively in acute care hospitals or within inpatient settings in the following specialties:

(a) Pathologists;

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(b) Consulting radiologists working within a hospital radiology department;

(c) Anesthesiologists or certified registered nurse anesthetists (CRNAs) except anesthesiologists and CRNAs with pain management practices in either hospital-based or ambulatory care settings;

(d) Emergency room providers; or

(e) Hospitalists.

(4) The department may phase implementation of the network to ensure access within all geographic areas. The director of the department will consider the following in establishing the network: percent of injured workers statewide who have access to at least 5 primary care providers within 15 miles, compared to baseline; percent of injured workers by county who have access to at least 5 primary care providers within 15 miles, compared to baseline; and availability within the network of broad variety of specialists necessary to treat injured workers.

The department may expand the health care provider network scope to include additional providers not listed in subsection (2) of this section, listed in subsection (3) of this section, and to out-of-state providers. For providers outside the scope of the health care provider network rule, the department and self-insured employers may reimburse for treatment beyond the initial office or emergency room visit.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01020, filed 1/3/12, effective 2/3/12.]

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WAC 296-20-01020 Health care provider network enrollment. (1) The department or its delegated entity will review the provider's application, supporting documents, and any other information requested or accessed by the department that is relevant to verifying the provider's application, clinical experience or ability to meet or maintain provider network requirements.

(2) The department will notify providers of incomplete applications, including when credentialing information obtained from other sources materially varies from information on the provider application. The provider may submit a supplement to the application with corrections or supporting documents to explain discrepancies within thirty days of the date of the notification from the department. Incomplete applications will be considered withdrawn within forty-five days of notification.

(3) The provider must produce adequate and timely information and timely attestation to support evaluation of the application. The provider must produce information and respond to department requests for information that will help resolve any questions regarding qualifications within the time frames specified in the application or by the department.

(4) The department's medical director or designee is authorized to approve, deny, or further review complete applications consistent with department rules and policies. Providers will be notified in writing of their approval or denial, or that their application is under further review within a reasonable period of time.

(5) Providers who meet the minimum provider network standards, have not been identified for further review, and are in compliance with department rules and policies, will be approved for enrollment into the network.

(6) Enrollment of a provider is effective no earlier than the date of the approved provider application. The department and self-insured employers will not pay for care provided to workers prior to application approval, regardless of whether the application is later approved or denied, except as provided in subsection (7).

(7) The department and self-insured employers may pay a provider without an approved application only when:

(a) The provider is outside the scope of the provider network per WAC 296-20-01010; or

(b) The provider is provisionally enrolled by the department after it obtains:

(i) Verification of a current, valid license to practice;

(ii) Verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query; and

(iii) A current and signed application with attestation.

(c) A provider may only be provisionally enrolled once and for no more than sixty calendar days. Providers who have previously participated in the network are not eligible for provisional enrollment.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01020, filed 1/3/12, effective 2/3/12.]

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WAC 296-20-02705 What are treatment and diagnostic guidelines and how are they related to medical coverage decisions?

(1) Treatment and diagnostic guidelines are developed by the department ~~recommendations~~ for the diagnosis or treatment of accepted conditions. These guidelines are ~~intended to guide~~ developed to give providers ~~through the~~ a range of the many treatment or diagnostic options available for a particular medical condition. Treatment and diagnostic guidelines are a combination of the best available scientific evidence and a consensus of expert opinion.

(2) The department may develop treatment or diagnostic guidelines to improve outcomes for workers receiving covered health services. As appropriate to the subject matter, the department may develop these guidelines in collaboration with the ~~department's formal advisory~~following committees:

- The industrial insurance medical advisory committee;
- The industrial insurance chiropractic advisory committee.
- The Washington state pharmacy and therapeutics committee.
- The Washington state health technology assessment clinical committee.

(3) In the process of implementing these guidelines, the department may find it necessary to make a formal medical coverage decision on one or more of the treatment or diagnostic options. The department, not the advisory committees, is responsible for implementing treatment guidelines and for making coverage decisions

that result from such implementation.

(~~2~~4) Network providers are required to follow the department's evidence-based coverage decisions and treatment guidelines and~~,~~ policies; and ~~may~~must follow other rigorously developed evidence-based national treatment guidelines appropriate for their patients when a ~~Dept~~department treatment guideline is not available.

[Statutory Authority: 2007 c 282, RCW 51.04.02 [51.04.020], 51.04.030. 08-02-020, § 296-20-02705, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-02705, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02705, filed 12/7/99, effective 1/8/00.]

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WAC 296-20-03015 What steps may the department or self-insurer take when concerned about the amount or appropriateness of drugs and medications prescribed to the injured worker? (1) The department or self-insurer may take any or all of the following steps when concerned about the amount or appropriateness of drugs the patient is receiving:

 Notify the attending ~~physician~~ provider of concerns regarding the medications such as drug interactions, adverse reactions, prescriptions by other providers;

 Require that the attending ~~physician~~ provider send a treatment plan addressing the drug concerns;

 Request a consultation from an appropriate specialist;

 Request that the attending ~~physician~~ provider consider reducing the prescription, and provide information on chemical dependency programs;

 Limit payment for drugs on a claim to one prescribing ~~doctor~~provider.~~.~~

(2) If the attending ~~physician~~ provider or worker does not comply with these requests, or if the probability of imminent harm to the worker is high, the department or self-insurer may discontinue payment for the drug after adequate prior notification has been given to the worker, pharmacy and physician.

(3) ~~Physician~~ Provider failure to reduce or terminate prescription of controlled substances, habit forming or addicting

medications, or dependency inducing medications, after department or self-insurer request to do so for an injured worker may result in a transfer of the worker to another ~~physician~~ network provider of the worker's choice. (See WAC 296-20-065.)

(4) Other corrective actions, up to and including removal from the provider network, may be taken in accordance with WAC 296-20-015, Who may treat and WAC 296-20-01100, Risk of harm.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03015, filed 12/7/99, effective 1/20/00.]

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WAC 296-15-310 Administrative organization to manage a self-insurance program. ~~Every employer certified to self-insure is obligated to comply with the provisions of Title 51 RCW and the rules and regulations of the department, and to have the necessary administrative processes in place to manage its self-insurance program. Each self-insurer is ultimately responsible for the sure and certain delivery of Title 51 RCW benefits to its injured workers and is accountable for all aspects of its workers' compensation program.~~

Every self-insurer must:

(1) Comply with the provisions of Title 51 RCW.

(2) Follow the rules, regulations and policies of the department.

(3) Comply with all final and binding orders issued by the department.

(4) Have the necessary administrative processes in place to manage its self-insurance program.

(5) Be responsible for the sure and certain delivery of Title 51 RCW benefits to its injured workers.

(6) Be accountable for all aspects of its workers' compensation program.

(7) Comply with all requirements of the health care provider network.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. 06-06-066, § 296-15-310, filed 2/28/06, effective 4/1/06.]

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WAC 296-15-330 Authorization of medical care. What are the requirements for authorization of medical care? Every self-insurer must:

(1) Authorize treatment and pay bills in accordance with Title 51 RCW and the medical aid rules and fee schedules of the state of Washington.

(2) Provide a written explanation of benefits (EOB) to the provider, with a copy to the worker if requested, for each bill adjustment. A written explanation is not required if the adjustment was made solely to conform to the maximum allowable fees as set by the department.

(3) Establish procedures to ensure prompt responses to inquiries regarding authorization decisions and bill adjustments.

(4) Comply with all requirements of the health care provider network. This includes:

(a) Verifying that workers are being treated by network providers.

(b) Ensuring only network providers are paid for care after the initial visit.

(c) Promptly assisting workers who are not being treated by a network provider to transfer their care to a network provider. Assistance must include:

- Notification within 14 days of receipt of information that the worker is seeing a non-network provider, and
- Information about how the worker can find a network provider in their area.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. 06-06-066, § 296-15-330, filed 2/28/06, effective 4/1/06.] both the date received and the location or entity that received it.

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